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Amendment No. 1 to SB2977

Fowler
Signature of Sponsor

AMEND Senate Bill No. 2977 House Bill No. 2790

By deleting in its entirety the first paragraph of Item 1 from Section 48, and by substituting instead the following language:

Item 1. Beginning July 1, 2000, the Commissioner of Finance and Administration is authorized to transfer no more than one-fourth (1/4) of the federal and state health care funds appropriated under this Act, except those funds appropriated to support the State Group Insurance Program, the Local Education Insurance Program and the Local Government Health Insurance Program, to the TennCare Program for the purpose of implementing any program approved by waiver, state plan amendment and/or state and federal legislation pursuant to the provisions of health care services to Tennesseans designated as eligible by TennCare, including specifically any premiums collected by the TennCare Program which are explicitly authorized to be appropriated to the program for the purpose of carrying out the provisions of TennCare. Thereafter, the Commissioner of Finance and Administration is authorized to transfer an additional one-fourth (1/4) of the federal and state health care funds appropriated under this Act to the TennCare Program, for the purpose of implementing any program approved by waiver, state plan amendment and/or state and federal legislation pursuant to the provisions of health care services to Tennesseans designated as eligible by TennCare, including specifically any premiums collected by the TennCare Program which are explicitly authorized to be appropriated to the program for the purpose of carrying out the provisions of TennCare at any time following the date upon which a state plan amendment to the TennCare Program waiver is submitted to the Health Care Finance Administration that:

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(a) Allows the imposition of a four-month residency requirement for the non-Medicaid eligible population;

(b) Allows uninsurables to be placed in a separate, high risk pool;

(c) Allows co-pays to be charged as follows and further allows primary care physicians to decline future treatment for non-payment of co-pays and conditions prescriptions upon payment of the pharmacy co-pay:

(1) Uninsurable

Income Level	Cost Sharing			
% of Poverty	OVC Co-Pay	Rx-Brand	Rx-Generic	ER Co-pay
0 – 199	$ 10	$ 10	$ 5	$ 15
200 – 249	$ 10	$ 15	$ 10	$ 15
250 – 299	$ 10	$ 15	$ 10	$ 15
300 – 349	$ 10	$ 15	$ 10	$ 15
350 – 399	$ 10	$ 15	$ 10	$ 15
400 – 499	$ 10	$ 20	$ 10	$ 15
500 – 599	$ 15	$ 20	$ 10	$ 25
600 – 699	$ 15	$ 20	$ 10	$ 25
700 – 749	$ 15	$ 20	$ 10	$ 25
750 – 799	$ 20	$ 25	$ 10	$ 50
800 - over	$ 20	$ 25	$ 10	$ 50

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(2) Uninsured

Income Level	Cost Sharing			
% of Poverty	OVC Co-Pay	Rx-Brand	Rx-Generic	ER Co-pay
0 – 199	$ 10	$ 10	$ 5	$ 15
200 – 249	$ 10	$ 15	$ 10	$ 15
250 – 299	$ 10	$ 15	$ 10	$ 15
300 – 349	$ 10	$ 15	$ 10	$ 15
350 – 399	$ 10	$ 15	$ 10	$ 15
400 – 499	$ 15	$ 20	$ 10	$ 25
500 – 599	$ 15	$ 20	$ 10	$ 25
600 – 699	$ 15	$ 20	$ 10	$ 25
700 – 749	$ 15	$ 20	$ 10	$ 25
750 – 799	$ 20	$ 25	$ 10	$ 50
800 - over	$ 20	$ 25	$ 10	$ 50

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(d) Revises premiums for the non-Medicaid population to be at least as follows:

(1) Uninsurable

Income Level	Premiums	
% of Poverty	Individual	Family
0 – 199	$ 50	$ 100
200 – 249	$ 100	$ 250
250 – 299	$ 150	$ 375
300 – 349	$ 200	$ 500
350 – 399	$ 200	$ 500
400 – 499	$ 200	$ 500
500 – 599	$ 200	$ 500
600 – 699	$ 250	$ 625
700 – 749	$ 250	$ 625
750 – 799	$ 250	$ 625
800 - over	$ 250	$ 625

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(2) Uninsured

Income Level	Premiums	
% of Poverty	Individual	Family
0 – 199	$ 50	$ 100
200 – 249	$ 100	$ 250
250 – 299	$ 150	$ 375
300 – 349	$ 200	$ 500
350 – 399	$ 200	$ 500
400 – 499	$ 200	$ 500
500 – 599	$ 200	$ 500
600 – 699	$ 250	$ 625
700 – 749	$ 250	$ 625
750 – 799	$ 250	$ 625
800 - over	$ 250	$ 625

(e) Allows vouchers to be used for such populations as the Commissioner of Finance and Administration shall determine to allow members of such populations to purchase health insurance in the private market;

(f) Allows the state to require documented proof of residency and income;

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(g) Opens enrollment to the non-Medicaid eligible uninsured population upon payment of the sliding scale premium as provided in subdivision (d), but beginning at a premium level equal to one hundred fifty dollars ($150) per individual and three hundred seventy-five dollars ($375) per family; and

(h) Allows a six (6) month waiting period for re-enrollment after disenrollment.

Thereafter, the Commissioner of Finance and Administration is authorized to transfer the balance of the federal and state health care funds appropriated under this Act to the TennCare Program, for the purpose of implementing any program approved by waiver, state plan amendment and/or state and federal legislation pursuant to the provisions of health care services to Tennesseans designated as eligible by TennCare, including specifically any premiums collected by the TennCare Program which are explicitly authorized to be appropriated to the program for the purpose of carrying out the provisions of TennCare at any time following the date upon which is issued one or more requests for proposals for outsourcing eligibility determinations and re-verifications, processing third party liability information, and determination of and billing and collecting premiums and reconciliation of premiums and eligibility criteria.